RHODE ISLAND DEPARTMENT OF HEALTH
Application for Health Plan Certification / Re-certification

Name of Applicant/Entity: _____

d/b/a in RI: _____

Name of Health Plan: _____

Address: _____

E-Mail Address: _____

Contact: _____ **Title:** _____

Phone: (____) _____ **FAX:** (____) _____

Total Rhode Island Enrollment: _____ **Total Entity Enrollment:** _____

Current HP Certificate #: _____ **Expiration Date:** _____

OWNERSHIP OF HEALTH CARE ENTITY:

☐ **Individual** ☐ **Partnership** ☐ **Corporation**

Attach a list with the names and addresses of all direct and indirect owners whether individual, partnership or corporation with percent ownership. The list shall include each owner (in whole or in part) of any mortgage, deed or trust, note or any other obligation secured (in whole or in part) by the health care entity or any of the property or assets of the health care entity. The list shall also include all officers, directors, and other persons of any subsidiary corporation owning stock, if the health care entity is organized as a corporation or all partners, if the health care entity is organized as a partnership.

Name of Health Plan Administrator/C.E.O.: _____

Brief Description of Health Plan: type/structure of Health Plan (discounted fee-for-service, ASO, PPO, HMO, etc.); services/benefits provided & to whom (describe population); risk-sharing arrangements with providers; and any financial incentives available to enrollees:

_____

_____

Does Health Plan perform its own utilization review? ☐ **YES** ☐ **NO**

If no, provide a signed copy of contract/agreement for each Agency that performs utilization review for the Health Plan.

Are any other Health Plan services contracted out, carved out, or delegated to another organization? ☐ **YES** ☐ **NO**

If yes, provide copy(s) of Contract(s)/Agreement(s).

SUPPORTING DOCUMENTS ARE REQUIRED IN ACCORDANCE WITH THE HEALTH PLAN APPLICATION GUIDELINES:

- Section I – Application Information – **TAB A**
- Section II – Disclosure Information – **TAB B**
- Section III – Policies and Procedures – **TAB C - J**
- Section IV – Provider Contracts – **TAB K**
- Section V – Other Supporting Documents – **TAB L - P**

I HEREBY SUBMIT THIS APPLICATION WITH ATTACHED ASSURANCES AND MATERIALS AS REQUIRED UNDER RIGL 23-17.13. THIS APPLICATION AND ATTACHED MATERIALS CONTAIN TRUE AND ACCURATE INFORMATION TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Person authorized by applicant Health Plan/Health Care Entity to submit this application:

Signature:

_____

Title: _____ **Date:** _____

Organization: _____

State of (.....)
County of (.....)

In....., in said county on this.....day of.....A.D. 20....., personally appeared before me..... Of..... who, after signing the foregoing ownership report in my presence, made oath that the facts stated in said report are true.

NOTARY PUBLIC

November 2003